

**DRAFT OAR NURSING FACILITIES VENTILATOR ASSISTED  
PROGRAM PAYMENT (VAP)**

**Division 70**

**NURSING FACILITIES/MEDICAID GENERALLY AND  
REIMBURSEMENT**

**411-070-0005**

**Definitions**

(X) "Bi-PAP" means bi-level positive airway pressure/spontaneous timed.

(X) "CPAP" means continuous positive airway pressure.

(X) "Ventilator" means a device to provide breathing assistance to individuals. This includes both positive and negative pressure devices.

(X) "Ventilator Assisted Program (VAP)" means a program that provides services to residents who are dependent on an invasive mechanical ventilation as means of life support as defined in 411 xxxSOQ.

(X) "Ventilator Assisted Program Unit" means a unit that meets the Ventilator Assisted Program criteria.

**411-070-0092 VENTILATOR ASSISTED PROGRAM (VAP) - MEDICAID  
PAYMENT**

(1) PAYMENT- A Medicaid eligible individual qualifies for the VAP reimbursement rate if the:

(a) Individual meets the criteria described in (2) of this rule; and

(b) The Nursing facility providing the ventilator services maintains an active endorsement pursuant to OAR 411-XX-XXXSOQ through 410 411-XXX-XXXSOQ

(2) An individual qualifies for reimbursement at the VAP rate if the individual:

- (a) Is chronically dependent on an invasive mechanical ventilator to sustain life;
- (b) Requires the ongoing use of a CPAP or Bi-Pap to sustain life; or
- (c) Is receiving necessary support and services during the transition from mechanical ventilation to a lower level of service.

(3) Ventilator dependent per diem rates shall cover all services in the bundled rate (OAR 411-070-0085) as well as all services, equipment, supplies and costs related to ventilator services. This includes services necessary to accommodate the needs of a person who qualifies for VAP Medicaid reimbursement pursuant to this rule. (b) The following services and supplies are not included in the VAP rate:

(A) Therapy services provided to residents by outside providers, excluding respiratory therapy and speech therapy required by OAR 411-SQO.

(B) Medical services by physicians or other practitioners excluding the services required by OAR 411-086-0200 and VAP Medical services required by OAR 411-SQ O.

(C) Radiology services, laboratory services, and podiatry services, excluding VAP laboratory services related to 411-SQO.

(D) Transportation for residents to and from medical services in vehicles that are not owned or leased by the facility or by any person who holds an ownership interest in the facility.

(E) Biologicals (e.g., immunization vaccines).

(F) Hyperalimentation.

(G) Prescription pharmaceuticals.

(H) Electronic devices to promote individual's communication and quality of life.

(4) ENDORSEMENT- Providers endorsed in accordance with OAR 411-xxx-SOQ for participation in the Ventilator Assisted Program shall receive payment in the form of 200% of the basic nursing facility rate established in accordance with OAR 411-070-0442.

(5) VAP PAYMENT PROHIBITED. APD may not provide VAP payments to a facility:

(a) With a waiver that allows a reduction of required licensed nurse staffing or certified nurse staffing.

(b) For an Individual whose needs require non-acute continuous positive airway pressure (CPAP) or bi-level positive airway pressure (Bi-PAP).

(c) If the facility is billing the complex Medical Add-On rate for the same individual for the same dates of service.

(6) PRIOR AUTHORIZATION. A nursing facility must obtain prior authorization from the Department prior to admitting an individual into a VAP Unit on a form designated by the Department.

(7) DOCUMENTATION- The endorsed nursing facility must maintain sufficient documentation as described in OARxxxSOQ.

(8) OVERPAYMENT FOR VAP MEDICAID PAYMENTS. The Department may collect monies that were overpaid to a facility for any period the Department determines the resident's condition or service needs did not meet the criteria for an eligible individual or determines the facility did not maintain the required documentation per OAR SOQ. The Department shall issue an order to the facility that includes the determination described in this paragraph and the facts supporting the determination as well as the amount of overpayment the Department seeks to recoup.

(9) ADMINISTRATIVE REVIEW.

(a) If a provider disagrees with the order of the Department regarding overpayment pursuant to paragraph (8) of this section, the provider may either request from APD an informal administrative

review of the decision or appeal the order as described in this paragraph.

- (b) If the provider request and informal administrative review, the provider must submit its request for review in writing within 30 days of receipt of the notice. The provider must submit documentation, as requested by APD, to substantiate its position. APD shall notify the provider in writing of its informal decision within 45 days of APD's receipt of the provider's request for review. APD's informal decision shall be an order in other than a contested case and subject to review pursuant to ORS 183.

(c) A provider who disagrees with the order issued pursuant to paragraph (8) above may appeal the order pursuant to a contested case proceeding. The provider must submit an appeal in writing within 60 days of receipt of the notice.

#### **411-070-0075**

##### **Rates - Facilities in Oregon**

The daily rate of payment for Oregon facilities shall be the basic rate plus either the medical add-on, Ventilator Assisted Program rate or the pediatric rate, as indicated.

#### **411-070-0430**

##### **Allocation Methods**

(1) The provider must use the allocation methods designated on the NFFS: COST - ALLOCATION METHOD.

- (a) Property -- Resident Days or Square Footage.
- (b) Administrative and General -- Actual Cost or Resident Days.
- (c) Other Operating Support -- Actual Cost or Resident Days.
- (d) Food -- Actual Cost or Resident Days.
- (e) Direct Care Compensation -- Actual Cost or Resident Days.

(f) Direct Care Supplies -- Actual Cost or Resident Days.

(g) Ventilator Assisted Program Expense -- Actual Cost or Resident Days.

#### **411-070-0442**

### **Calculation of the Basic Rate, Complex Medical Add-on Rate and Ventilator Assisted Program Rate**

(1) The rates are determined annually and referred to as the Rebasing Year.

(a) The basic rate is based on the statements received by the Department by October 31 for the fiscal reporting period ending on June 30 of the previous year. For example, for the year beginning July 1, 2018, statements for the period ending June 30, 2017 are used. The Department desk reviews or field audits these statements and determines the allowable costs for each nursing facility. The costs include both direct and indirect costs. The costs and days relating to pediatric beds and VAP beds are excluded from this calculation. The Department only uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(b) For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any) or VAP unit, are inflated by the DRI Index, or its successor index. The DRI table as published in the fourth quarter of the year immediately preceding the beginning of the payment year will be used. Costs will be inflated to reflect projected changes in the DRI Index from the mid-point of the fiscal reporting period to the mid-point of the payment year (e.g., for the July 1, 2018 rebase, the midpoint of the fiscal reporting period is December 31, 2016 and the mid-point of the payment year is December 31, 2018).

(c) For each facility, its allowable costs per Medicaid day is determined using the allowable costs as inflated and resident days, excluding pediatric days as reported in the statement.

(d) The facilities are ranked from highest to lowest by the facility's allowable costs, per Medicaid day.

(e) The basic rate is determined by ranking the allowable costs per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day that are just above and just below the applicable percentage to arrive at a basic rate at the applicable percentage. The applicable percentage for the period beginning July 1, 2018 is at the 62nd percentile.

(2) The Department provides an augmented rate to nursing facilities who qualify under the Quality and Efficiency Incentive Program as described in OAR 4-070-0437. An acquisition plan must be submitted to the Department on or after October 7, 2013 and on or before June 30, 2016. The purchasing operator must meet all requirements in OAR 411-070-0437(3) in order to receive the augmented rate. The qualifying nursing facility is paid the augmented rate for each Medicaid-eligible resident.

(3) Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran's Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department as of July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.

(a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.

(b) For each three-month period beginning on or after July 1, 2016 and ending June 30, 2018, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 63rd percentile for a reduction of 1,500 or more beds.

(B) 62nd percentile for a reduction of 1,350 or more beds, but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds, but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds, but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds, but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds, but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds, but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds, but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds, but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds, but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

(c) For the period beginning July 1, 2018 and ending June 30, 2026, the Department shall reimburse costs, as set forth in section (1) of this rule, at the 62nd percentile.

(4) The complex medical add-on rate is 40% of the basic rate.

(5) The Ventilator Assisted Program rate is 200% of the basic rate.

**411-070-0465**

**Uniform Chart of Accounts**

305 - Private Resident - Ventilator Assisted Program - This account includes room and board revenue for Ventilator Assisted resident services including HMO payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid basic rate needs criteria.

310 - Medicaid Resident - Ventilator Assisted Program - This account includes room and board revenue from all sources for VAP Medicaid residents.

345 – Ancillary Revenue – Ventilator Respiratory Therapy – This account includes revenue from Respiratory Therapy services provided.

950 –Vent Unit Medical Director Compensation – This account is for reporting all compensation received by the Vent Unit Director who provides services for the VAP residents.

951 Nursing Compensation - Ventilator Assisted Nurses - This account is for reporting all compensation received by Nurse and Nursing assistant employees of the facility who provide nursing services for VAP residents.

952 - Respiratory Therapist Compensation - Ventilator Assisted - This account is for reporting all compensation received by Respiratory Therapist employees or contractors of the facility who provide therapy services in Ventilator Units.

953 - Contracted Nursing - Ventilator Assisted - This account is for reporting the expense attributable to employment agencies that provide registered nurse employees on a fee and salary basis in a Ventilator Unit.

954 - Ventilator Rental - This account is for reporting expense of a ventilator.

955 - Oxygen and Medication - Ventilator Assisted - This account is for reporting the expense of all oxygen (gas) and concentrator rentals

and is for reporting all expenditures meeting the criteria of 411-070-0085(2)(j) in a Ventilator Unit.

956 – Other Vent related Supplies – This account is for the reporting of other related supplies incurred in a Ventilator Assisted Program.

957 - Other (Identify) - Ventilator Assisted - This account is for all other expenses incurred in a Ventilator Assisted Program.